Case Management Issues that Impact Revenue Cycle

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Objectives

➢ Examine how case management supports hospital financial goals

➢ Review key strategies for working together to foster greater clinical and financial integration

➢ Explain the role of case management at the many steps in the patient journey

➢ Conflicts- none (I pay taxes and want it spent wisely)
It’s Not Enough to...

Get an order for a service
Schedule the service
Perform the service
Bill for the service
Revenue is at Risk

- Ambulatory Services
  - Physician Practices
  - Ambulatory Surgery Center
  - Infusion Clinic
  - Oncology Clinic
  - Imaging
  - Lab
Hospital Services

- ED
- Outpatient Procedures
- Observation
- Inpatient
- LTACH
- Psych
- SNF
- Acute Rehab
Forces Moving the Bar

➢ Medicare Advantage
➢ Managed Medicaid
➢ High Deductible Health Plans
➢ Medicare Part D
➢ Commercial PBMs
➢ Advanced Imaging Authorization
➢ New Technology – Robotics, lasers, EMRs
➢ New Treatments - Hep C, Cancer, Generics
➢ The Myriad of Auditors
➢ (The Unknown Future of Healthcare)
It’s Not Enough...

for the contract to specify the reimbursement for a service if the contract never lets you bill for that service.

You also have to be able to not only collect the money but also keep the money.
One Patient’s Journey

Mrs. Smith – 76-yr-old female with right sided weakness and lethargy, called 911, no family with her

“Stroke code” called, patient immediately taken back to trauma bay

ED doc sees pt stat, CT stat with small hemorrhage
It Starts in the ED

- Who is the patient?
  - Photo ID
  - Risk of identity theft
  - Insurance/ Medicare/ Medicaid card

- Is insurance still in effect?

- Is patient eligible for COBRA?

- Case Mgmt counts on Registration to get the insurance information in the chart
ED – The Hospital’s Front Door

➢ Constant pressure from every side

➢ Accurate Registration v. get them in a bed

➢ Faster throughput v. complete evaluation

➢ Patient satisfaction v. doing what is indicated

➢ Emergency v. Urgency v. Convenience

➢ ED docs v. Hospitalists / Primary Care Docs / Specialists
EMTALA and ED Treatment

➢ “It is not appropriate for a hospital to seek, or direct a patient to seek, authorization to provide screening or stabilizing services from the individual’s health plan or insurance company until after the hospital has provided a medical screening exam and initiated stabilizing treatment for an emergency medical condition...

But...

➢ a hospital may follow a reasonable registration process, including asking for insurance information, as long as it does not delay screening and treatment.”  
  
  GAO Report to Congress, June 2001
Insurance-Agnostic- Treat All the Same

- Out of network specialists- higher copay
- Off formulary prescriptions- no Rx
- Non-contracted post-acute care- big bills
- That’s not very patient-centered!
Self Pay ED Patients

➢ ED Physicians reluctant to release pt: Risk of liability if lack of follow up.
  ➢ Lack of accessible follow up care
  ➢ Lack of relationship with pt
  ➢ Risk of non-compliance
  ➢ The “WIGS Syndrome” – What if I get sued?

➢ CM/SW: Referral to community / charitable services
  ➢ Have current lists available with addresses and contact information
Self Pay ED Patients

- MDs: Focus on emergency condition
  - Avoid workups of non-emergency problems
  - Avoid “while I’m here” syndrome

- Hand off to PCP/clinic for follow up
  - CM assistance to identify PCP
  - Facilitates safe transition to community care
  - Document hand off for risk reduction (medical and liability)
  - Documented phone call; fax hard copy of ED record to PCP office; give copy to patient/family
  - Can complete diagnostic work up through PCP office
Case Management in the ED

➢ High percent of admissions are through the ED

➢ Every patient who will occupy a hospital bed should be screened for correct status.

➢ If you’re not going to staff CM when patients need review, you should close the ED.
“Admission Avoidance” in ED

➢ If admission or observation not medically necessary but lacks safe discharge: “outpatient in a bed”
  ➢ Avoid “Social admissions”- can’t admit as inpatient
  ➢ Not covered: Custodial care; Awaiting placement
  ➢ Chronic and minor complaints – not now!

➢ CM: Arrange alternative care directly from ED
  ➢ SNF (No three day rule for managed care, pioneer ACO)
  ➢ Acute rehab; Assisted living; Psych hospital
  ➢ Family; Home; Home health services
  ➢ Set up a Senior Services SWAT Team for ED patients
Mrs. Smith is Admitted by ED Doctor

Patient transferred to ICU
Admitted to Hospitalist on call
Stroke care plan initiated
Consultations with Neurosurgery, Neurology, Cardiology
Regulation Flash Briefing

Medicare FFS requires an inpatient admission order from a practitioner with admitting privileges that is countersigned prior to discharge.

➢ If ED docs write orders, do they have privileges to admit? If not, needs cosignature
➢ If residents write admit order, always needs cosignature
➢ If NPs have privileges, we are not sure if that order needs cosignature
Mrs. Smith is Admitted by Patient Access

- Seen in ED, no family, registered based on info from paramedics - name and address

- Patient Access carried forward her demographic info from last hospital encounter - mammogram done 18 months ago - Fee-for-Service Medicare

- Patient moved to ICU
When Hospital Care is Needed

➢ Screen for proper admission status
  ➢ First level review with IQ/MCG
    ➢ RN review with criteria
  ➢ Second level review with Physician Advisor/Physician Advisory Service
    ➢ Criteria are only first step- lots of false negatives

➢ Notify payer if applicable
  ➢ Hospitals open 24/7 but insurers open 10/5
Notification v. Authorization

➢ Can a payer deny a claim for an admission when proper notification was made?

➢ Can a payer retro-deny when they do concurrent review thru your EMR?

➢ Can a payer deny a claim for an admission when notification could not be made due to payer factors?
  ➢ If you could not get denial concurrently, how can you get proper order on chart?
Inpatient admission denied on retro review

“Approve” Observation billing

But there is no order for observation hours

Outpatient with 8+ hrs Obs- $2,275
Outpatient w/o 8+ hrs- ~$1,200

Can you add Obs hours to claim to get full payment? If not, lost $1,000 per patient
What Status?

- Admission v. Observation
- 2 Midnight Rule for Medicare
- 2 Midnight Rule +/- MCG for UHC
- Unknown rules for many plans
- Do contracts specify admission rules? If they don’t, they should!
What is the 2 MN Rule?

Two and a half step process

1- Does the patient require care that can only be safely provided in the hospital?

2- How many midnights is the patient expected to require in the hospital until able to safely move to a lower level of care (regardless of who is going to pay for that care)?

2.5- Always admit if second midnight is necessary.
Brief Diversion- Lots of Lost Revenue

➢ Fee for service Medicare
  ➢ If the patient requires hospital care beyond the second midnight, you must admit them as inpatient.

➢ If the patient does not require hospital care, find out why they are staying. A paying customer could be occupying that bed!

➢ Caveat- convenience midnights don’t count. How much are your avoidable days costing you?
How do you use criteria?

If a patient passes Inpatient or Observation criteria, or fails discharge screening, that means they require hospital care. You then need to count midnights to determine correct status.

Pass Inpt- could be **inpt** or **obs**, dep on illness and plan
Pass Obs- **obs** if first day or **inpt** if second day
Fail discharge- **Inpt** or **obs** dep on the day and the plan

Don’t meet criteria at all- get a secondary review
New 2 Midnight Rule Exception- 1-1-2016

Patients with an expectation of under 2 MN who the physician judges to require inpatient care based on severity of signs and symptoms and risk of adverse event can be admitted as inpatient on a case-by-case basis.

➢ May apply to life-threatening illness that can be quickly fixed
  ➢ Acute MI, complete heart block, anaphylactic shock
Where does Mrs. Smith Belong?

➢ ICU - 1:2 nursing, most technology intensive, most patient movement restrictive
➢ Telemetry - higher RN:pt ratio, pt still wired - comforts MD but restricts patient, massively overused
➢ Med/surg - no telemetry, patients free to move about, lowest cost for payers
➢ Do contracts pay variable rates by unit? Are there criteria for use of each unit? Does anyone know those exist?
➢ Is this addressed on multidisciplinary rounds? Do we even have rounds?
Mrs. Smith goes to the ICU

➢ In ICU, CM confirms two midnight expectation and checks that inpatient admission order is authenticated. Reviews IQ for ICU criteria.

➢ CM/SW participates in Multidisciplinary Rounds, ensures PT, OT, speech ordered. Seeks out family.
What is done in the Hospital?

➢ The WIGS Syndrome
  ➢ Address every finding completely prior to discharge.
  ➢ ~15% of ED patients get a CT scan
  ➢ ~25% of those CT scans have an incidental finding
  ➢ Doctors feel compelled to evaluate every finding
What is done in the Hospital?

➢ While you are here, let’s check...

➢ Most time in the hospital is spent doing nothing.

➢ Let’s get that...MRI, mammogram, colonoscopy

➢ Let’s call all your specialists!
What is done in the Hospital?

- New treatments and technology abounds
  - FDA/CMS/Insurance approvals
  - Medical Necessity, Appropriate Use Guidelines
- Equipment costs - fixed and per procedure
- Staff training
- Reimbursement - DRG / APC / fee schedule
- Precertification requirements
- Expertise of physicians
Mrs. Smith doesn’t need surgery

- Day 3 repeat CT stable, on rounds CM reviews IQ, meets for transfer to acute. Intensivist consulted, writes order for tele.
- CM asks “why tele?”
- MD states “It’s the next level down. Better nursing care”
- CM “educates” MD, agrees to neuro unit w/o tele
Mrs. Smith

➢ SW found family, get insurance information, patient has Medicare Advantage plan.
➢ Registration contacted to update demographics.
➢ Insurer contacted to authorize admission.
How long to stay in Hospital?

➢ DRG payment- want to optimize LOS- move to next LOC when stable, both in hospital and discharge

➢ Per diem/% of charges- want to ensure every day is medically necessary
  ➢ Approve day 1-4, 7, deny day 5, 6
  ➢ Need notes beyond “stable, CPM”
Determining Length of Stay

➢ GMLOS - Mean LOS established by Medicare per DRG
   ➢ Requires determining a concurrent working DRG
   ➢ Serves as a guide, not a red line
➢ MCG Care Guidelines - Goal LOS
   ➢ Assumes optimal recovery, decision making, and care
➢ IQ - Discharge screens
Where are the Delays?

➢ Patient factors
  ➢ Comfortable in hospital
  ➢ But risk VTE, HAC, med error, deconditioning, falls
  ➢ Slow to pick SNF
  ➢ Family needs time to visit
  ➢ Weren’t told of SNF need until last minute
Where are the Delays?

➢ Physician Factors
  ➢ FFS v. DRG payment
    ➢ Bundled payment initiatives
    ➢ Audits of physician billing practices
  ➢ Ease of Rounding
  ➢ “Better” care in hospital
  ➢ “My patient” v. “Just covering”
  ➢ “Don’t know the patient yet”
Speaking of Physician Billing

Are you missing out on revenue?

This provider did not bill Medicare for any 5's.

BERNADETTE UCHE IGUH

AVERAGE FOR FAMILY MEDICINE PROVIDERS IN TEXAS

Hover over each slice to see percentage breakdown.
Are you at risk of audit and fraud?

Office Visits

Medicare reimburses office visits using a five-point scale, with five being the most intensive and costly. The chart below shows what percentage of this provider’s office visits were reimbursed at each level. A higher than average proportion of costly visits is not necessarily an indication of a problem, but it may be worth asking about.

More than 90 percent of this provider’s office visits were billed as 5s.

Links at www.ronaldhirsch.com
Where are the Delays?

➢ Payer Factors
   ➢ FFS Medicare - 3 day Inpatient requirement
   ➢ Medicaid - availability of facilities
   ➢ Medicare Dis-Advantage/Mis-Managed Medicaid/Commercial
     ➢ Need to meet their arbitrary standards
     ➢ Need to get authorization - M-F 8-5
The Insurance Contracting Pitfalls that Finance Executives Need to Know

“Unbeknownst to the hospital’s finance staff are the daily difficulties that often are encountered trying to get even the most basic services approved by the MA plans. And as a result, your patients may be experiencing poorer outcomes and a higher risk of readmission – and providers may soon be seeing a decline in patient satisfaction scores.”

RACMonitor.com, May 17, 2015 eNews
"I couldn't agree more! What a nightmare. We are forced to treat patients differently which is wrong on many levels. Payers are keeping patients in the acute hospital setting longer waiting for the discharging facilities to obtain the authorizations that used to be obtained the same day when the hospitals were in charge of the auth. Average wait is 72 hrs for SNF and 14 days for LTAC!"

LinkedIn comment from CM Director
What must the MA Plan Cover?

MA plans must provide their enrollees with all basic benefits covered under Original Medicare. Consequently, plans may not impose limitations, waiting periods or exclusions from coverage due to pre-existing conditions that are not present in Original Medicare.

MA enrollees must have access to all medically necessary Parts A and B services. However, MA plans are not required to provide MA enrollees the same access to providers that is provided under Original Medicare.

Medicare Managed Care Manual, Ch 4
What’s the Reality?

➢ MA Plan will rarely approve LTACH, acute rehab or even SNF
➢ Contracted home care agency has bad reputation
➢ DME supplier will not deliver supplies in a timely manner
➢ YOUR patient satisfaction will suffer because it is always the hospital’s fault!
Mrs. Smith gets Better

➢ Physiatrist recommends Acute Rehab
➢ CM initiates discharge plan
➢ Started on Cozaar, Crestor, Lantus, Plavix
➢ Spends three days on stroke unit, persistent weakness and speech difficulties. Felt stable for discharge.
➢ Follow-up CT scan ordered by neurosurgery for 4 weeks
Mrs. Smith

- Family participates in discharge planning
- Hospital day 3 CM contacts MA plan for auth for Acute Rehab; 48 hours later, denied.
- MA plan authorizes SNF, provides contracted facility list. Nearest is 10 miles, passing 5 other facilities.
- Family visits facility, not pleased, refuses transfer, wants her to go home
- 2 days spent organizing home care services
Post-Discharge Issues

- Pharmacy Benefit Managers, Medicare D Plan
  - Formulary restrictions, step therapy
  - Pre-authorizations

- Follow up testing issues
  - Who orders test?
  - Who follows up on results? - “Not my patient” syndrome
Mrs. Smith

➢ Home care arranged thru contracted provider; cannot see her for 48 hours, discharge delayed
➢ DME company slow to respond to calls (also an issue with FFS Medicare now)
➢ Family goes to pharmacy, meds need preauthorization, Hospitalist off duty, PCP “did not order them,” discharge delayed again
➢ Finally gets home, LOS 11 days, 5 days of delay
Readmissions

- Medicare - no pay if same day, same diagnosis
  - QIO may review and determine to be preventable

- MA Plans - make up their own rules
  - “To match our readmissions policy for Aetna Medicare members, we’re also extending the review timeframe for readmissions from 2 days to 30 days for our Aetna commercial members.”
Elective Services

➢ Know your authorization requirements

➢ Nothing happens without an authorization
  ➢ Who is responsible for pre-auth?
    Provider/Hospital

➢ What happens if service provided without auth?
  ➢ Can auth be obtained post-test?
  ➢ Do you have procedure to get that done?
Surgery - What status?

- FFS Medicare - Inpatient Only List
- Commercial insurers - whatever they want
- It’s not about the status, it’s about the payment!
  - Outpatient Hysterectomy - $8,000
  - Inpatient Hysterectomy - $6,500
High Cost Medications

➢ Oncology
  ➢ What requirements for administering?
    ➢ NCCN guidelines for appropriateness
    ➢ Correct Setting? - UHC Hospital facility-based intravenous medication infusion policy- URG-9
  ➢ Correct dose?
    ➢ Avastin- 20% of claims denied – dose incorrect  http://goo.gl/KOdpwM
Blood Products

➢ What are your hospital transfusion triggers?
  ➢ Blood is costly and dangerous
  ➢ Guidelines are evolving on blood use

➢ What do you do with off-hours transfusions/infusions
  ➢ Cannot change observation if done on medical unit
  ➢ Free care in a hospital bed that cannot be occupied by a “paying” customer
Summary

➢ Case managers want to provide efficient care

➢ Finance wants to get paid for the services provided by the hospital

➢ Understanding each other’s struggles benefits both

➢ What’s in your Contract?
Questions?

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